

**ANNUAL REPORT
WORKER'S COMPENSATION MANAGED CARE ORGANIZATION**

Please complete the following. (Fax to 609-633-0527) by April 30th

(Name of Preparer and Contact Person)

Signature of Preparer)

Telephone:

Fax:

Email Address:

(Name of WCMCO)

Main Administrative Address:

(Street and Number)

(City, State and Zip Code)

Internet Website Address:

Telephone:

Fax:

New Jersey Office:

(Street and number)

(City, State and Zip Code)

Telephone:

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If you are contracting out for any of the following services, please indicate below:

CONTRACTED SERVICES

PPO Networks:

(PPO Network (s) if applicable)

(Street and number)

(City, State and Zip Code)

Telephone:

(Secondary PPO Network (s) if applicable)

(Street and number)

(City, State and Zip Code)

Telephone:

Please identify the name, title and telephone number of the person and organization responsible for the following:

Case Management:

Quality Assurance:

Utilization Review:

Billing:

Grievance Program:

Fraud Detection Program:

Early Return to Work Program:

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Please complete the following two charts. (See definitions on the next page)
Do not attach financial statements or reports.

WCMCO	Income	Expenses	Gain or Loss
2004			
2003			

WCMCO	# of New Cases	#Claims submitted to MCO	Charges by Providers	Paid to Providers
2004				
2003				

- ☐ The WCMCO has no business to report
- ☐ The WCMCO is not in contract with any insurers
- ☐ The WCMCO is in contract with insurers but has no business to report

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DEFINITIONS

SCOPE OF WHAT IS TO BE REPORTED

Report only Managed Care Worker's Compensation activity in New Jersey.
Do not report the entire financial results of the entire company.

If a WCMCO has subcontracted any claim function to another entity, please include the figures from them. The claims of any carrier who identified your WCMCO for the purposes of the premium reduction should be included. Any time an employee presents for injury, the claims should be included no matter which of your contracted networks is involved. If an employer is identifying your WCMCO as their managed care network, then their claims should be included whether case management was involved or not.

CLAIM: A claim is defined as each bill for a separate encounter for medical services. Please use date bill was paid for reporting purposes.

CASE: Number of new cases opened during the calendar year. A case is defined as a work-related injury or illness resulting in a need for medical care. This may involve numerous claims over an extended period of time.

CHARGES BY PROVIDERS: Charges are defined as total provider billed charges, both in and out-of-network, for which payment is legitimately due. This excludes charges related to duplicate bills and charges related to medical care that is denied.

PAID TO PROVIDERS: Payments made to in and out-of-network medical providers for eligible medical expenses.

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In accordance with N.J.A.C: 11:6-2.4 (a)
Worker's Compensation Managed Care Organizations are required to submit an annual report.

In accordance with N.J.A.C: 11:6-2.4 (b)
WCMCO's are required to report all changes in operations to the Department of Banking and Insurance within 30 days of said change(s), including but not limited to, contractual changes, name changes, mergers, acquisitions, sales of the WCMCO and/or the preferred provider organizations serving as the network or any other changes. Changes as described above should be submitted under separate cover with all supporting documentation to the following address:

New Jersey Department of Banking and Insurance
Office of Life and Health Insurance
Valuation Bureau
20 West State Street, 11th floor
PO Box 325
Trenton, New Jersey 08625

CERTIFICATION:

- ☐ This is to certify that no changes described by N.J.A.C: 11:6-2.4(b) are applicable to the calendar year 2004.

(Printed Name)

(Signature and Title)

- ☐ This is to certify that changes described by N.J.A.C: 11:6-2.4(b) have occurred during the calendar year 2004 and were submitted on _____ or will be submitted by _____.

(Printed Name)

(Signature and Title)